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Navigating new waters: How the Inflation Reduction Act alters government funding for Medicare Part D

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The 2025 national average Part D direct subsidy (DS) will increase to $142.67 as plan sponsors take on additional Part D risk in 2025.

This article discusses the key drivers behind the increased direct subsidy as well as the future implications for plan sponsors.

KEY FINDINGS

Impact of the Inflation Reduction Act on Medicare Part D government funding

1. Increased direct subsidy (DS) for 2025

- The 2025 national average Part D direct subsidy will rise to $142.67 PMPM, the highest since the program's inception. This increase is driven primarily by the Part D benefit redesign under the Inflation Reduction Act (IRA), which shifts more financial risk to plan sponsors.

2. Major drivers of subsidy increase

- **Benefit redesign:** Plan liability in the catastrophic phase increases from 20% to 60%, and the true-out-of-pocket (TrOOP) limit drops from $8,000 to $2,000.
- **Premium stabilization:** The Basic Beneficiary Premium (BBP) is capped at 6% growth, directly impacting the DS.
- **Drug trends and rebates:** Increased utilization of high-cost drugs like GLP-1 agonists and potential decreases in manufacturer rebates.

3. Regional low-income benchmark (LIB) variations

- The standard deviation of regional low-income premium subsidy amounts (LIPSAs) has nearly tripled, indicating significant regional cost variations. The minimum LIPSA is $15.83 (NM) and the maximum is $72.34 (NY).

4. Shift in federal funding mechanisms

- There is a notable shift from federal reinsurance to direct subsidy payments. The share of national average reinsurance as a percentage of national average reinsurance and direct subsidy decreased to 22% in 2025, increasing the financial risk for plan sponsors.

5. New programs and adjustments

- **Medicare Prescription Payment Plan (M3P)**: Allows beneficiaries to smooth cost-sharing over the year, adding administrative and potential bad debt expenses for plans.
- **Voluntary premium stabilization demonstration**: Offers BBP reductions and caps on premium increases, along with enhanced risk corridor protections for standalone PDPs.

These key findings highlight the substantial changes and increased complexities that health plan sponsors need to navigate for the 2025 plan year under the IRA. Understanding these shifts is crucial for strategic planning and maintaining profitability.

On July 29, 2024, the Centers for Medicare and Medicaid Services (CMS) announced the 2025 Part D national averages and regional low-income benchmark (LIB) amounts. These amounts are critical for both Medicare Advantage organizations (MAOs) and standalone prescription drug plan (PDP) sponsors to understand both the level of Part D revenue subsidized by the federal

government for the following year and their final Part D premium amounts. The 2025 plan year introduces material changes to the national averages due to the Part D benefit redesign from the Inflation Reduction Act (IRA).[1] Figure 1 displays the Part D national average amounts, released by CMS.

Figure 1: Part D national averages, per member per month

	2025	2024	Change ($)
National Average Monthly Bid Amount	$179.45	$64.28	$115.17
Capped Base Beneficiary Premium (reflecting premium stabilization)	36.78	34.70	2.08
Uncapped Base Beneficiary Premium (not reflecting premium stabilization)	55.98	39.35	16.63
National Average Reinsurance	40.08	90.03	(49.95)
National Average Direct Subsidy	142.67	29.58	113.09

Sources: Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information (CY2024)
Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information

What are the key drivers of the increased Part D direct subsidy relative to 2024?

Unprecedented Part D program changes drive the 2025 direct subsidy amount to its peak since program inception, the largest of which is the Part D benefit redesign, but other factors were also at play for plan sponsors bidding in 2025. This section describes the key drivers of the increased national average monthly bid amount (NAMBA). Due to the IRA's premium stabilization, most of these factors contribute to a higher DS on what is essentially a dollar-for-dollar basis. While we cannot determine the exact magnitude of most of the drivers listed in this section, we believe each to be a material driver of the change in DS relative to 2024.

IRA Part D benefit redesign

Relative to 2024, plan liability in the catastrophic phase increases from 20% to 60% of gross Part D costs stemming from a significant decrease in federal reinsurance liability. Further, the true out-of-pocket (TrOOP) limit decreases from $8,000 in 2024 to $2,000 in 2025. While these amounts are not perfectly comparable because of different components accumulating to TrOOP in 2024 and 2025,[2] the resulting decrease in member cost sharing required to satisfy the TrOOP puts upward pressure on the NAMBA. Other provisions of the benefit redesign, such as the phase-in of the new Manufacturer Discount Program (MDP) liabilities, also drive the NAMBA upward, given that plan sponsors pay the difference between the full MDP liability and the reduced amount for certain manufacturers. The benefit redesign comprises a large majority of the NAMBA increase and corresponding DS increase.

Base Beneficiary Premium (BBP) stabilization

With the 2025 BBP held at 6% above the 2024 BBP, the resulting DS is $142.67, which is $19.20 higher than the DS would have been if premium stabilization were not in place. This is the only driver of the 2025 DS that can be reliably quantified.

It is important to note that this growth limit is only applicable to the BBP, and not to individual plan premiums, which are permitted to grow beyond 6% annually. However, plan premium growth is still curbed via the BBP stabilization mechanism because the higher DS offsets plan bid amounts and therefore lowers basic beneficiary premiums, all else equal.

Drug trend and rebates

The expected growth in utilization and unit cost trends of drugs covered under the Part D benefit are critical assumptions in any year of bid submissions, and in particular under the new benefit design where plans take on more risk. For the 2025 plan year, Part D plan sponsors continue to expect upward pressure on trends for the growing antidiabetic class of glucagon-like peptide-1 (GLP-1) agonists[3] such as Ozempic and Mounjaro. These drugs continue to be an important consideration for Part D plans, and the expected increase in their utilization is likely an incremental driver of the higher NAMBA.

Manufacturer rebates directly offset the plan's expected claim liability, after offsets for federal reinsurance, and therefore rebate assumptions play a major role in the ultimate NAMBA and DS amounts. In 2025, plans will share fewer rebate dollars, on average, with the federal government due to the much lower federal reinsurance. In 2024 and prior, plans shared approximately 35% of rebates with the federal government to offset reinsurance costs. In 2025, we estimate this amount will decrease to 10% to 15%, on average, based on Milliman analyses. Therefore, manufacturer rebates are even more valuable to Part D plans in 2025 and beyond than in prior years in their effort to keep Part D net costs low – though the delta between the value in list price discounts and rebates has narrowed relative to prior years.

On the other hand, many pharmaceutical manufacturers are facing immense financial headwinds in 2025 due to changes in the amount they must pay in mandatory discounts via the new MDP which replaces today's Coverage Gap Discount Program (CGDP). To the extent these financial headwinds caused lower rebates to be assumed in 2025 bids, the NAMBA would incrementally increase as a result.

Risk adjustment

CMS released a new Part D risk adjustment (i.e., RxHCC) model for 2025, recalibrated using more recent data years and to reflect the 2025 Part D benefit design. CMS also finalized separate risk score normalization factors for Medicare Advantage and prescription drug (MAPD) plans and for standalone PDPs.[4] The separate normalization factors are meant to account for the lower risk score trends for beneficiaries enrolled in PDPs relative to their MAPD counterparts. The 2025 RxHCC model and new normalization factors affect each Part D plan sponsor differently, depending on their degree of diagnosis capture, their makeup of low-income subsidy (LIS) or non-LIS beneficiaries, and their composition of MAPD plans and PDPs.

Medicare Prescription Payment Plan (M3P)

In 2025, for the first time, Part D beneficiaries will have the option to pay $0 at the pharmacy counter and instead "smooth" their cost sharing over the course of the plan year via the M3P.[5] While developing 2025 Part D bids, plan sponsors were asking themselves key questions around this program, which affected the ultimate 2025 NAMBA.

- **Operational expenses:** A combination of efforts from plan sponsors, their pharmacy benefit manager (PBM), and/or third-party vendors will support Part D plans' operations of the M3P. Plans likely assumed an incremental increase to their projected 2025 administrative expenses attributable to the operation of the new program, where the magnitude of additional costs would be highly sensitive to their assumed program participation rate.
- **Bad debt:** Beneficiaries who opt into this program will be billed retrospectively for their cost-sharing payments. Payments the plan cannot collect will be treated as "bad debt," for which the plan bears responsibility. Plans estimated this bad debt amount, which is considered an administrative expense. This assumed level of bad debt contributes to the standardized basic bid amount, and directly factors into the 2025 DS amount.

Increased Part D utilization

Many of the IRA provisions work toward improving the affordability of drugs in the Part D program. Specific to 2025, Part D beneficiaries will have a lower out-of-pocket limit than ever before in Part D, with the introduction of a $2,000 maximum out-of-pocket (MOOP) limit. Based on Milliman analyses, many Part D beneficiaries enrolled in enhanced plans will pay less than $2,000 per year, due to supplemental coverage accumulating to the MOOP in addition to beneficiary cost sharing. Further, under the M3P beneficiaries will have the option to pay $0 at the point of sale (POS) and instead pay the cost sharing for their drugs in multiple payments throughout the year.

In 2025, many plan sponsors expect an increase in specialty and high-cost brand drug utilization as a direct result of the new cost-sharing limits and flexibilities created by the IRA. In particular, they expect higher increases in utilization from non-LIS beneficiaries more so than their LIS counterparts, whose cost sharing is already heavily subsidized by the government.

Overall, there is significant uncertainty around exactly how much utilization will increase across these several factors, and we expect estimates of increased utilization levels varied by carrier. Not all of these factors directly affect the basic benefit,[6] but we expect this assumption was an important driver of the 2025 NAMBA and therefore DS, given the large potential impact on plan bid amounts.

Profit margin and administrative expenses

Alongside projected claim costs, projections for profit margin and administrative expenses (i.e., projected retention) are also key assumptions affecting a plan's bid amount.

- **Retention allocation:** For enhanced Part D plans, a portion of projected retention is allocated to the basic benefit and the remainder is allocated to the supplemental benefit based on the relative proportion of each. For basic plans, the full retention amount is allocated to the basic bid amount, given there is no supplemental component. Driven by the significant increase in the basic benefit costs, the proportion of basic to supplemental costs skews further toward the basic component in 2025, on average. This change in the basic and supplemental relativities drives the NAMBA upward, all else equal, because a greater portion of the retention expenses are allocated to the basic benefit and therefore the plan's standardized basic bid amount.
- **Profit margin:** Part D plans typically set profit margins as a percentage of the plan bid amount, rather than on a per member per month (PMPM) basis. With the expected increases to plan benefit costs in 2025, the profit margin percentage is applied to a higher benefit cost amount therefore increasing the profit margin dollars PMPM, all else equal. Further, some plans publicly signaled ahead of June bid submission that they may increase margins to maintain profitability.[7,8] While continuing to comply with CMS margin requirements, plans may have assumed higher margin percentages relative to prior years in light of 2025 benefit pressures.

Plan sponsor behavior

One of the more challenging aspects of estimating the national averages in advance of June bid submissions is attempting to predict the strategic paths major carriers may take. Given the high concentration of enrollment in the large, national carriers, the pricing decisions each carrier makes can have a significant impact on the actual DS amount.

Ahead of the release of the Part D plan landscape files this fall, it is unclear what plan design decisions were made for the 2025 plan year, but we describe some scenarios and the potential impact of each on the NAMBA, below.

- **PDP consolidations:** Certain carrier bid changes in 2024, the increase in Part D plan risk in 2025, and the implementation of new PDP crosswalking restrictions in 2026 lead us to expect some PDP consolidation in 2025. Multiple carriers greatly increased enhanced plan premiums in 2024, which indicates cost pressures and, based on historical precedent, may indicate forthcoming crosswalks. Further, the 2025 CMS Final Rule introduces new limitations on the ability of PDP sponsors to crosswalk or consolidate plans by limiting premium increases for crosswalked beneficiaries and effectively hinders the plan from introducing a new, lower-premium, enhanced plan in the same year.[9]

PDP bid changes and/or crosswalks can have material impacts on the NAMBA, but the directions of such impacts vary depending on the exact scenario.

- **Benefit changes:** In response to increasing plan risk and revenue pressures, we expect many plans will adjust benefit designs by way of higher deductibles and coinsurance in place of copays for certain drugs. In particular, we expect that some MAPD plans will switch from flat copays on the non-preferred drug tier (i.e., typically tier 4) to coinsurance benefit designs and some may elect to switch the preferred brand tier (i.e., typically tier 3) to coinsurance as well, if possible while complying with actuarial equivalence requirements. These benefit changes reduce the cost of the Part D benefit for the plan sponsor, which may be necessary for plan sponsors facing MA revenue pressures (e.g., those with lower star ratings). While adjusting benefits on enhanced plans does not directly affect the basic claim liability (i.e., the basis for the plan's standardized basic bid amount and the NAMBA), reducing supplemental liability by way of making benefits leaner affects the NAMBA because the allocation of retention (i.e., non-benefit expenses and profit margin) is based on the proportion of basic and supplemental plan liability. As benefits become leaner, more retention is allocated to the basic benefit, which increases the NAMBA and the DS, all else equal.
- **Service area exits:** Some carriers also publicly stated they may exit certain service areas if unable to meet profitability. To the extent the carrier composition will significantly change in a particular region in 2025, the regional LIB amount will be affected.
- **Basic PDP market strategies:** In 2024, many carriers appeared to change strategies around attempting to bid below the LIB and pursue auto-assigned LIS beneficiaries.[10] The 2025 RxHCC model and normalization factors bring tailwinds for Part D plan sponsors to pursue LIS PDP beneficiaries, but these changes may not provide enough subsidy dollars to compensate for higher plan risk in 2025 for certain plans. The forthcoming landscape files will reveal which plan sponsors continued the 2024 trend of bidding above the LIB and which plan sponsors are pursuing auto-assigned LIS beneficiaries, and in which regions. To the extent carriers continue to increase basic PDP premiums, both the NAMBA and the LIBs in affected regions would increase as a result.

How have regional low-income premium subsidy amounts (LIPSAs) changed in 2025?

Similar to the NAMBA and DS, regional LIBs increased considerably in 2025. The LIPSA is equal to the difference between the regional LIB and DS. The average LIPSA decreased by $0.81, from $41.02 in 2024 to $40.21 in 2025.

While the average LIPSA change was relatively small, we observed an unprecedented increase in regional LIPSA variation in 2025. Figure 2 displays the standard deviation of LIPSAs for the last five years.

Figure 2: Historical standard deviation of regional per member per month LIPSA

Year	Standard Deviation
2021	4.39
2022	4.46
2023	4.37
2024	4.63
2025	13.36

The standard deviation among LIPSAs nearly tripled from 2024 to 2025. In fact, LIPSA standard deviation has remained between $3 and $5 for every year from program inception to 2024. In 2024, the minimum and maximum LIPSAs were, respectively, $28.37 (Texas) and $48.72 (New York). In 2025, the minimum and maximum LIPSAs are $15.83 (New Mexico) and $72.34 (New York), respectively.

The benefit redesign is the primary driver of this increased variation, as each plan sponsor's bid amounts are increasingly sensitive to the projected allowed cost. Therefore this dynamic more closely aligns LIPSAs with the regional variation in allowed cost, we have historically observed. Further, we may see an incremental increase in the spread between regional LIPSAs given that the benchmark is set equal to the BBP of the lowest PDP offering in the situation where the LIPSA would otherwise be negative (i.e., the regional LIB is less than the DS).

How does the change in federal government funding mechanics affect Part D plan sponsors?

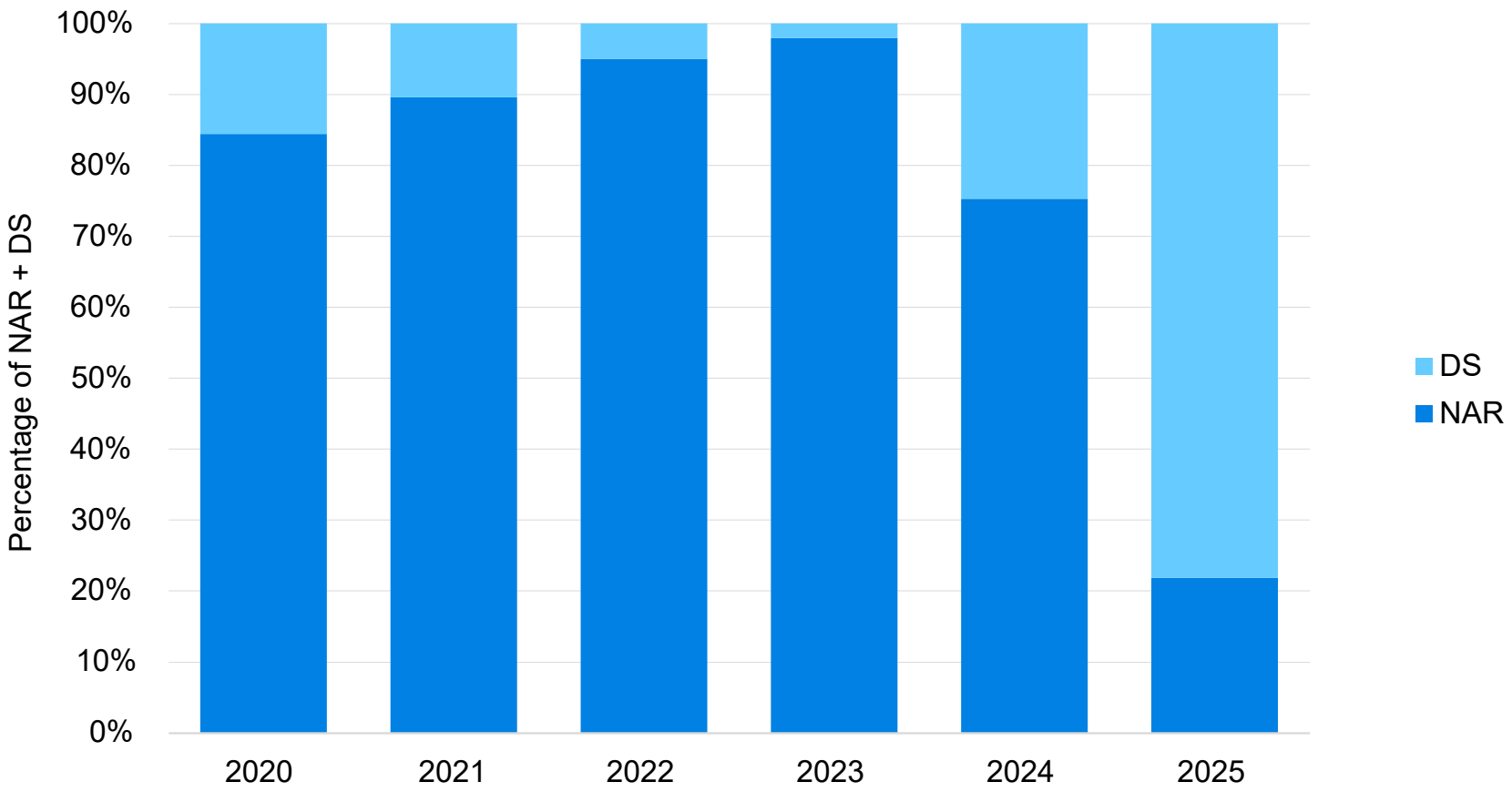
The federal government funds the Part D program via key subsidy amounts:

- Federal reinsurance
- Direct subsidy
- Low-income cost sharing (LICS)
- LIPSA

The combination of the Part D redesign impacts on plan liability along with BBP stabilization led to an unprecedented DS amount for 2025. However, this increase in the DS is simultaneous with a large decrease in federal reinsurance funding—largely shifting the mechanism in which the government funds the Part D program.

Figure 3 focuses on the shift between the proportion of national average net federal reinsurance versus DS from 2020 to 2025.

Figure 3: Shift in national average federal reinsurance vs. direct subsidy



In 2024, the historical trend of declining direct subsidy amounts reversed, largely driven by the IRA's elimination of catastrophic cost sharing and the 2024 CMS Final Rule requiring pharmacy rebates to be reflected at the POS. These two factors put significant upward pressure on the 2024 NAMBA and therefore the DS.

In 2025, the share of the national average reinsurance (NAR) as a percentage of NAR and DS decreased to 22%. This shift in funding mechanism is noteworthy because of the distinct differences between these two subsidy payments:

- **Federal reinsurance**
  - Revenue component estimated in plan bids and correspondingly paid as a level, monthly subsidy to plans to cover the federal reinsurance portion of claim costs.
  - As plans incur federal reinsurance expenses at the POS, revenue payments can be used to offset these costs. Plans generally have positive cash flows due to the level prospective payments being typically higher than federal reinsurance POS costs in earlier parts of the plan year. Plans settle with CMS at year-end for differences between revenue and actual expenses.
  - Plans bear risk for cash flow to pay POS claim costs throughout the year, but otherwise they will eventually be made whole by CMS for deviations between actual and expected federal reinsurance costs. This expense can generally be considered "pass-through" as plans bear little risk beyond cash flow.
- **Direct subsidy**
  - Because the DS is used to derive the basic beneficiary premium from the standardized basic bid amount for each plan, the inherent assumption is that plans would be fully compensated for plan claim costs via direct subsidy and beneficiary premium if actual plan costs and risk scores emerge consistent with plan bids. However, that is rarely the case.
  - DS payments are made at risk, meaning payments differ at the individual beneficiary level based on their Part D risk score, or relative morbidity and age and demographic characteristics. Further, in 2025, risk scores also vary by plan type due to varying risk score normalization factors between MAPD plans and standalone PDPs.
  - DS payments are neither fully nor directly reconciled with CMS. The Part D risk corridor, which is a two-sided risk arrangement between plans and CMS, offers some protection to plans against adverse experience but plans still bear a portion of the risk and incur financial losses if experience deviates significantly from bid projections.

In theory (i.e., assuming that plans on average correctly predict the total bid plus reinsurance), decreasing the federal reinsurance funding in favor of higher direct subsidy payments keeps plans whole financially, on average, but in practice plan risk increases significantly due to how risk adjustment, risk corridors, and federal reinsurance change under Part D benefit redesign. The key dynamics are:

1. **Reinsurance is essentially risk-free for plans**—while plans receive an advance subsidy of reinsurance amounts based on their bids, the full amount of reinsurance in any year is reconciled against actual amounts late in the following year.
2. **The combination of premium and direct subsidy payments for any individual beneficiary constitutes a capitation rate for the individual beneficiary.** The plan accepts risk for any discrepancy between the risk adjuster's estimate of cost and the member's actual claims. Like all risk adjusters, the Part D risk adjuster is almost

certainly inaccurate at a beneficiary level but is expected to perform better as the number of beneficiaries enrolled in the plan increases. However, predicted costs may still vary significantly from actual costs, even with a large beneficiary population. This is likely to be particularly impactful for any plan that has a greater than average number of members with unusually high (or low) claims.

3. **The Part D risk corridor program provides some protection for plans, but this is based on a percentage of the capitated amount.** While Part D redesign significantly increased this amount, it did not change the percentages associated with the risk corridor (though CMS announced separate changes via the optional, new proposed PDP premium stabilization demonstration, discussed below), meaning that total plan costs (including reinsurance) would have to vary significantly more relative to expectations to obtain the same amount of risk corridor protection.

This increased level of risk does cut both ways—while plans that have unusually high costs will have to bear more of those costs before their risk exposure is limited, plans that are able to reduce costs or otherwise capture value relative to expectations will see more of the benefit before they begin to share these benefits with the federal government. As plans gain more experience with the redesigned Part D benefit, it is likely that the market will respond to take advantage of potential benefits or avoid potential pitfalls.

Voluntary Standalone PDP Premium Stabilization Demonstration

The CMS announcement on July 29, 2024, also introduced a voluntary premium stabilization demonstration for standalone PDPs beginning in 2025. The demonstration consists of three elements:

- **BBP reduction:** For PDPs with more than $15 in total beneficiary premium (including both basic and supplemental premiums), the BBP will be reduced by $15. PDPs with a total beneficiary premium less than $15 will have total premium reduced to $0. This will increase the plan's direct subsidy by the total amount of BBP-attributed premium reduction.
- **Plan premium increase limit:** Total plan premium (basic plus supplemental) increases will be limited to $35 year-over-year after the $15 reduction in premium is applied via the reduced BBP. If PDP sponsors participate in this demonstration, beneficiaries will not see monthly plan premium increases greater than $35. The direct subsidy, at the plan level, will similarly increase to account for the incremental reduction in premium needed to satisfy the $35 year-over-year limit.[11] Of note, the direct subsidy payments are subject to sequestration and therefore the revenue trade-off between premium and direct subsidy is not one- for-one in this situation.
- **Risk corridors:** In instances where a PDP experiences losses, risk corridor thresholds will be set at 2.5% and 5% above the target amount instead of 5% and 10% above. Furthermore, CMS's share of losses above the upper threshold (5% in 2025) will increase from 80% to 90%. This means the demonstration program offers greater risk corridor protection for participating PDPs.

In a CMS memo following the July 29 announcement, CMS indicated that the published low-income subsidy benchmarks will not be recalculated and therefore will be based on pre-demonstration bid amounts, while LIPSAs paid to participating plans and LIS beneficiary auto-assignment will be determined using post-demonstration premiums. As such, a basic PDP that participates in the demonstration will be determined eligible for automatic LIS beneficiary assignment if its adjusted (post-demonstration) premium is below the original regional LIPSA published on July 29, 2024.

Part D sponsors must include all of their PDP contracts in the demonstration—including Employer Group Waiver Plans (EGWPs)—if they wish to participate in the demonstration. EGWPs are only eligible for and subjected to the first element of the demonstration. Standalone PDPs needed to indicate intent to participate to CMS by August 5, 2024. Furthermore, CMS intends for this demonstration to continue for at least three years (including 2025), though available BBP reduction, premium increase caps, and increased risk corridor downside protection may change as PDP sponsors gain more experience with the new Part D benefit. If PDP sponsors do not elect to participate in 2025, CMS indicated that they will not be eligible to participate in future years.

Next steps

While it may take some time for plans to respond to the broader trends affecting the DS, they face immediate actions to finalize plan offerings for the upcoming year. The tremendous increase in the DS increases the likelihood that plans may have to significantly change their allocation of rebates, enhance their benefits, or reduce the generosity of benefits to return to the premium and revenue levels indicated in their initial bid submission. This is likely to create some unusually large changes in benefits for MAPD plans, in particular, relative to previous years, which in turn could lead to greater beneficiary plan shopping and turnover.

The forthcoming 2025 CMS landscape files will help us understand more specific drivers of the 2025 DS at the bid and plan sponsor level. Plan offerings in the market, along with their corresponding premiums, benefits, network, and formulary decisions will be public later this year, allowing for a more thorough review as the 2025 Part D landscape continues to unfold.

As plan sponsors turn their attention to the contract year (CY) 2026 bid cycle in the coming months, they will soon begin thinking about estimating the 2026 DS, which will bring a new set of challenges with Medicare drug price negotiation altering the POS prices of several major brand drugs. In combination with the continued applicability of premium stabilization and the continued phase-in of the MDP, careful planning and evaluation of the magnitude of these effects will be crucial to successful plan performance in the years ahead.

Background: What are the different national average components, and how are they calculated?

The Part D national average amount calculations are prescribed by the Social Security Act (SSA)[12] and are defined as follows:

NAMBA[13]: The national average monthly bid amount (NAMBA) reflects the enrollment-weighted average "standardized bid" amount, or the amount Part D plan sponsors expect to pay for the claim costs of their projected plan beneficiaries plus administrative costs and profit margin. The standardized bid amount reflects a 1.0 risk score basis, normalizing for any difference in plan revenue that would be attributed to risk adjustment. This calculation is based on all individual (i.e., non-employer group) Part D plan bids submitted by MAOs and PDP sponsors, excluding those of special needs plans (SNPs) and some other plans.[14] Of note, the NAMBA is based on projected costs for the basic benefit only, as any additional costs for supplemental (i.e., enriched) benefits must be paid for via supplemental beneficiary premiums only.

Part D BBP: The SSA prescribes the BBP calculation of 25.5% of total Part D program costs per beneficiary for basic Part D coverage. However, the IRA introduced a premium stabilization component beginning in 2024, which limits the BBP growth to 6% annually. As in last year's announcement, CMS provided two amounts for 2025—the calculation reflecting premium stabilization and the calculation reflecting 25.5% of program costs (before premium stabilization). In addition to serving as the basis for member-paid premiums, the BBP is used to derive the national average DS amount, which is the difference between the NAMBA and the actual BBP.

National average reinsurance (NAR): The federal government pays a portion of claim costs in the final phase of the Part D benefit, the catastrophic phase. Through plan year 2024, gross federal reinsurance has comprised 80% of gross costs in the catastrophic phase, but the IRA adjusts this liability to 40% and 20% of gross costs in 2025, for, respectively, non-applicable (i.e., largely generic) drugs and applicable (i.e., largely brand) drugs. The national average reinsurance amount underlying the un-stabilized BBP and the NAMBA reflects the risk-adjusted average federal reinsurance amount after accounting for rebate offsets.[15]

DS: The DS reflects the average monthly subsidy from the federal government to cover a portion of beneficiary premiums. In initial June bid submission, plan sponsors estimate the DS in order to derive the basic beneficiary premium from the plan-standardized basic bid amount.

DS = NAMBA - BBP
Plan Basic Beneficiary Premium = Plan Standardized Bid Amount - DS

Following the CMS announcement of the final national averages, plan sponsors will resubmit their bids using the final DS to calculate the final 2025 plan premiums for each of their bids.

During the plan year, plan sponsors are paid a direct subsidy amount for each beneficiary, equal to the plan's standardized basic bid multiplied by the beneficiary's risk score, less any basic beneficiary premium the plan charges.

Paid DS = (Plan Standardized Basic Bid Amount x Beneficiary Risk Score)
- Plan Basic Beneficiary Premium

LIB amounts: The published regional LIB amounts, typically equal to the average regional standardized bid amount for LIS beneficiaries minus the DS,[16] reflect the maximum amount the federal government will pay to plans via the LIPSA on behalf of beneficiaries who are eligible for extra help from the government. These amounts are particularly important for basic PDPs targeting LIS beneficiaries, who attempt to bid below the benchmark. A bid below the benchmark means that LIS premiums are $0, and LIS beneficiaries who do not select a plan with part D coverage are randomly assigned to a PDP offering basic coverage at or below the regional benchmark.[17] Further, the LIB amounts are critical for certain Medicare Advantage (MA) plans targeting dual-eligible beneficiaries such that these beneficiaries pay $0 premium out-of-pocket.

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[1] Cline, M., Karcher, J., Klaisner, J., & Klein, M. (August 2022). Weathering the Reform Storm. Milliman Brief. Retrieved August 2, 2024, from **https://www.milliman.com/en/insight/weathering-the-reform-storm**.

[2] Notable differences in TrOOP accumulation between 2024 and 2025 include manufacturer discount payments (2024 only) and supplemental benefits provided by Part D sponsors (2025 only).

[3] Ally, AJ, Bell, D., Craff, M. et al. (August 2023). Payer Strategies for GLP-1 Medications for Weight Loss. Milliman White Paper. Retrieved August 4, 2024, from **https://www.milliman.com/en/insight/payer-strategies-glp-1-medications-weight-loss**.

[4] Klein, M., Petroske, J.J., & Rodrigues, D.I. (April 26, 2024). A Prescription for Change: How the 2025 Medicare Part D Risk Adjustment (RxHCC) Model Overhaul Will Affect Risk Scores. Milliman White Paper. Retrieved August 4, 2024, from **https://www.milliman.com/en/insight/prescription-for-change-2025-medicare-part-d-risk-adjustment-model**.

[5] Corrao, B. & Klein, M. (October 2, 2023). Medicare Prescription Payment Plan: What Do Plan Sponsors Need to Know? Milliman White Paper. Retrieved August 4, 2024, from **https://www.milliman.com/en/insight/medicare-prescription-payment-plan-for-plan-sponsors**.

[6] Specifically, accumulation changes only affect enhanced plans, while other general expected increases in utilization due to member behavior will be at least partially attributable to the basic benefit.

[7] Humana (April 24, 2024). Humana Inc Earnings Call: Edited Transcript. Retrieved August 4, 2024, from https://humana.gcs-web.com/static-files/87de54ab-20cb-45fe-9bd9-232346e09c58.

[8] CVS (May 1, 2024). CVS Health Corp.: Q1 2024 Earnings Call. Retrieved August 4, 2024, from https://s2.q4cdn.com/447711729/files/doc_financials/2024/q1/CVS-1Q24-Earnings-Transcript.pdf.

[9] See https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit#h-67. Among other changes to plan crosswalks, CMS formalized a cap on premium increases at the greater of the BBP and 100% of the current plan BBP, requires members in enhanced PDPs to be crosswalked into the least expensive PDP available, and prohibits plans from offering a new enhanced PDP after terminating an enhanced PDP without following CMS's crosswalk exception process.

[10] Cline, M. & Klaisner, J.K. (November 27, 2023). Low-Income Disruption and the $0 Premium Introduction: 2024 Individual Medicare PDP Market Turbulence. Milliman White Paper. Retrieved August 4, 2024, from https://www.milliman.com/en/insight/low-income-disruption-0-dollar-premium-introduction-2024-individual-medicare-pdp-market.

[11] This was clarified in the July 30, 2024, CMS memo Announcement of Actuarial User Group Call and Clarifications Regarding Voluntary Part D Premium Stabilization Demonstration for Standalone Prescription Drug Plans.

[12] Specifically, in Section 1860D-13(a).

[13] See https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-F.

[14] The NAMBA calculation excludes Special Needs Plans (SNPs), MA private fee-for-service (PFFS) plans, Medicare Medical Savings Account (MSA) plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and Section 1876 Medicare Cost plans.

[15] Part D plans must share a portion of direct and indirect remuneration (DIR) with the federal government to offset gross reinsurance amounts, where this portion is derived as the plan projected gross reinsurance divided by the plan projected total gross costs. Additionally, enhanced plan reinsurance is adjusted to remove any increased claims utilization associated with the enhanced benefit so that it only reflects claims attributable to basic Part D coverage.

[16] If this calculation is less than the BBP for the least expensive basic PDP in the region, then the benchmark is set at that plan's BBP.

[17] Basic PDPs with premiums within $2 of the regional LIB can elect to waive that premium amount to retain their current LIS enrollment, though they are not eligible for the auto-assignment process. A basic PDP bid above that level results in a loss of any auto-assigned LIS enrollment and potentially other LIS beneficiaries as LIS beneficiary premiums would no longer be $0.

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